

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/03/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155561</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/01/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN HOME &amp; REHABILITATIVE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>231 N JACKSON ST</b> <b>OAKLAND CITY, IN 47660</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00136186 and Complaint IN00137106.</p> <p>This visit was done in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaint IN00131239 completed on 7/2/13, and the PSR to the Investigation of Complaint IN00133590 and Complaint IN00134089 completed on 8/29/13.</p> <p>Complaint IN00136186 - Substantiated, no deficiencies related to the allegations are cited.</p> <p>Complaint IN00137106 - Unsubstantiated, due to lack of evidence.</p> <p>Survey dates: September 30 and October 1, 2013</p> <p>Facility number: 000327 Provider number: 155561 AIM number: 100273920</p> <p>Survey team: Anne Marie Crays RN</p> <p>Census bed type: SNF/NF: 89 Total: 89</p> <p>Census payor type: Medicare: 8 Medicaid: 58 Other: 23 Total: 89</p> <p>Sample: 7</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1  Good Samaritan Home and Rehabilitation Center was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaint IN00136186 and Complaint IN00137106.  Quality review completed on October 2, 2013, by Jodi Meyer, RN	F 000			